STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES

Office of Pharmacy Service
Prior Authorization Criteria

FIRAZYR® (icatibant)

Prior Authorization Request Form

Firazyr is indicated for the treatment of acute attacks of hereditary angioedema (HAE)

I. Firazyr Criteria for Approval

1) The diagnosis of hereditary angioedema (HAE) must be clinically established by, or in consultation with, an allergist or immunologist; **AND**
2) Patient must be eighteen (18) years of age or older; **AND**
3) Diagnosis of HAE is documented based on evidence of low C4 level **AND** one of the following:
    a. A low C1 inhibitor (C1-INH) antigenic level; **OR**
    b. A normal C1-INH antigenic level and a low C1-INH functional level;
AND
4) Patient should not be concurrently taking an angiotensin converting enzyme (ACE) inhibitor or estrogen replacement therapy; **AND**
5) Patient must be experiencing at least one (1) symptom of a moderate or severe attack (i.e. swelling of the face, throat, or abdomen).

Approval: Duration is for six (6) months with six (6) injections covered per month.

Additional injections are available via prior authorization request provided the criteria for continuation of therapy have been satisfied.

Continuation of Therapy Criteria:

1) Medical records documenting frequency of acute HAE attacks and the patient's response to therapy must be provided.

2) If the patient is experiencing more than one (1) acute HAE attack per month, medical records documenting use of a long-term prophylactic therapy (LTP) or the clinical rational for avoiding LTP must be provided.

References

1) Firazyr package insert 01/07/2015
2) Lexi-Comp Clinical Application 01/07/2015
3) http://www.uptodate.com/contents/hereditary-angioedema-treatment-of-acute-attacks

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